

Bureau Talk

October 2013

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>

ELDER ABUSE

SEE IT. STOP IT. PREVENT IT.

Elder Abuse & Neglect Hotline

If you suspect an elderly person is at risk for abuse or neglect, you can call the Department of Health and Senior Services' hotline at 1-800-392-0210, or the Missouri Attorney General's office new hotline at 1-800-286-3932.



Encryption of Emails



A few years ago, the Department of Health and Senior Services (DHSS) adopted and implemented Proofpoint Encryption. The software safeguards health and other confidential information that is emailed from a domain other than a state agency.

The new encryption feature provides an additional safeguard. If an email sender fails to type “encrypt” in the subject line, the email message will still be encrypted if it appears to contain a Social Security number or other confidential information and is sent from a domain other than a state agency.

The new encryption feature became active on Sept. 16, 2013. If you receive an encrypted email and are unable to read it, please notify the sender.

QIES Technical Support Office (QTSO) User Guides Move



The QTSO website’s User Guides have been moved from the bottom of the “Hospice Information and OASIS Download” pages. They are now located on a new page titled “User Guides & Training.”

Direct links to “User Guides & Training” are available below.

- Hospice User Guides & Training: <https://www.qtso.com/hospicetrain.html>
- OASIS User Guides & Training: <https://www.qtso.com/hhatrain.html>

Pain, THE 5TH VITAL SIGN

It's a known fact that pain is considered the "fifth vital sign." A speaker at a recent surveyor training stated that more than 50 million Americans are disabled because of pain. The symptom most expected and most feared by dying patients is pain, and the cost of treating it in 2010 was \$560 to \$635 billion dollars. Yet surveyors are finding that patients are not getting appropriate pain assessments.

Many deficiencies are being written for both home health and hospice surveys because of poor pain assessments or poor follow-up. A good pain assessment should include most or all of the following:

- Is the patient experiencing pain? Perhaps use the phrase, "Are you hurting?" instead of "Are you having pain?"
- What are the patient's goals or wishes for pain control?
- What is the intensity of the pain? How severe is it? How much does it hurt when it is the worst? How much does it hurt when it is the best?
- If not experiencing pain at the time, did the patient use any pharmacological or non-pharmacological measures to alleviate it?
- What type of pain is the patient experiencing? Identify and document the characteristics of the pain.
- What precipitates the patient's pain?
- Where is the pain located? Is it in one place? Does it travel anywhere else? Did it start elsewhere and has it now moved to one spot?
- What alleviates the patient's pain? What is effective and what isn't?
- If the patient doesn't take his or her pain medications, explore why.
- Does the patient's pain affect the patient's sleep pattern, mood, appetite, mobility, behavior, relationships, activities, etc.?

A deficiency may also be cited if a patient has pain and an agency does not follow-up with the patient's physician. Although a good pain assessment may have been conducted, often a surveyor finds no documentation about coordination between clinicians (therapy assistants and therapists, LPNs and nurses, therapists and nurses, etc.) or follow-up with the physician. On rare occasions, patients may be satisfied with their pain, though it is not controlled. In those instances, patients' satisfaction must be documented in their medical records.



Rubber Stamp Signatures



A June 18, 2013, *MLN* (Medicare Learning Network) *Matters* article clears up confusion about rubber stamp signatures. The article, published by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), says, "For medical review purposes, the Centers for Medicare & Medicaid Services requires that services ordered/provided be authenticated by a handwritten or electronic signature. With few exceptions, stamped signatures are not acceptable, as described in Chapter/Section 3.3.2.4 of the *Medicare Program Integrity Manual*. Change Request (CR) 8219 adds another exception to the manual. Under the added exception, CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973, in the case of an author with a physical disability who can provide proof to a CMS contractor of his/her inability to sign." By affixing a rubber stamp to a document, a provider certifies that he or she has reviewed the document.

The official instruction, CR8219, was issued to your Medicare contractor and may be viewed at <http://go.cms.gov/1aSy04U> on the CMS website.

If you have questions, please contact your Medicare contractor at their toll-free number, listed at <http://go.cms.gov/H6x1Vm> on the CMS website.

PRN for Aide Tasks



The Centers for Medicare & Medicaid Services (CMS) has not provided new guidance on "as needed" or PRN aide tasks, though an accrediting organization's recent publication indicates otherwise. The bureau contacted CMS' Central Office and received the following information:

"We have not issued any new guidance re: aides. The duties of the aide as listed on the aide care plan should be discussed with the clinician responsible for developing the care plan and the patient/caregiver, and specified as clearly as possible on the care plan. Patient choice should be discussed, and tasks assigned should be based on patient assessment, need, and support of the overall plan of care. The registered nurse is responsible for assessing the patient's capabilities and assigning appropriate tasks. Changes in the care plan need to be discussed with the clinician. This is not new guidance. It is a long standing CMS policy that you cannot use PRN on aide care plans."

Home Health

Home Health Advance Beneficiary Notice (HHABN)

As many of you are aware, the Centers for Medicare & Medicaid Services (CMS) have issued changes with the HHABN. As the state survey agency, we have asked CMS for direction regarding our role with these changes. At this time no direction has been given.

After researching the issue on the CMS website, we do, however, know the following:

- For items and services provided on or after Dec. 9, 2013, the HHABN (Form CMS-R-296) will no longer be valid, and home health agencies (HHAs) must use the Advance Beneficiary Notice of Non-coverage (ABN) (Form CMS-R-131) and the Home Health Change of Care Notice (HHCCN) (Form CMS-10280). HHABNs issued prior to Dec. 9, 2013, for ongoing, repetitive services will remain in effect for the time period indicated on the notice, up to one calendar year from the date of issuance.
- The ABN is effective for up to one year and must be issued annually for ongoing, repetitive services when the notice is required.
- To download the ABN, HHCCN, and the instructions for both forms, go to <http://go.cms.gov/14MhOnD>.
- The Medicare Learning Network articles outlining the two CMS Change Requests (CR 8403 and CR 8404) can be found at <http://go.cms.gov/1bD1SmK> and <http://go.cms.gov/19URZl3>.
- Questions regarding the new forms can be emailed to: RevisedABN_ODF@cms.hhs.gov.



Family Care Safety Registry

The Missouri State Highway Patrol informed the Family Care Safety Registry (FCSR) that the name-based criminal record search fee will increase by \$1.00, to \$11.00, effective Nov. 1, 2013. The increase stems from a mandatory Highway Patrol statute change. The change affects the FCSR registration fee, which also increases to \$11.00 effective Nov. 1, 2013. Hard-copy worker registration forms postmarked on or after Nov. 1, 2013, will be returned if they contain the incorrect fee. Updated worker registration forms can be downloaded no later than Oct. 31, 2013, at <http://on.mo.gov/19UN4Ta>, or may be obtained via the FCSR's toll-free call center at 866/422-6872.

Hospice Issues

Hospice 101

The Missouri Hospice and Palliative Care Association recently asked the bureau to do a presentation for the association's Hospice 101 class, held in Columbia, Mo. Judy Morris, HFNC, and Bonnie Quick, HFNC, presented information relative to the regulatory aspect of hospice. Please find their PowerPoint presentation attached (ATTACHMENT A). If you have handouts from previous Hospice 101 presentations, please disregard them and use this updated information.



Bereavement



The Missouri Hospice and Palliative Care Association recently held a meeting in Jefferson City and asked the bureau to do a presentation on the regulatory aspects of bereavement. Judy Morris, HFNC, obliged with a PowerPoint presentation (ATTACHMENT B).

Discharge for Cause

The July 2009 *Bureau Talk* defines the procedure to follow if your agency has a "Discharge for Cause." We are getting more and more calls regarding this issue and felt it necessary to remind agencies of the procedure again.

As per the State Operations Manual (SOM), Section 2082 - Discharge from Hospice Care, "Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State law. The situations under which a hospice may discharge a patient are addressed in regulation at 418.26 and include the following situations:

- The patient moves out of the hospice's service area or transfers to another hospice.
- The hospice determines that the patient is no longer terminally ill.
- The hospice determines, through its policy to address discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative, to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. (continued on page 7)

Hospice Issues *(continued from page 6)*



The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered.
- Make a serious effort to resolve the problem(s) presented by the patient's (or other persons in the patient's home) behavior or situation.
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.
- Document in the clinical record the problem(s) and efforts made to resolve the problem(s).

Prior to discharging a patient for any reason stated above, the hospice IDG must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge, and his/her review and decision should be included in the discharge note.

The hospice notifies its Medicare administrative contractor (MAC) and SA of the circumstances surrounding the impending discharge. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (i.e., Adult Protective Services) or health care facilities before discharge."

The bureau has never approved or disapproved a discharge for cause, nor will it. To fulfill the requirements of the SOM, if a hospice determines a patient is to be discharged for cause, the hospice agency is to e-mail the bureau (Lisa.Coots@health.mo.gov) with the circumstances surrounding the impending discharge. Please identify the patient in your e-mail with the patient's initials only. This information will be placed in your agency file here at the bureau. Please note that if a complaint should be filed, the bureau is still required by regulation to conduct an investigation.

Notifying the bureau of the discharge for cause does not exempt your agency from a citation if, during a complaint investigation, the bureau finds a patient's discharge rights were violated or your agency policies were not followed.

Quarterly Q & As

Due to the government shutdown, the CMS OASIS Quarterly Q&As were not released Oct. 16, 2013, as previously expected. The bureau will notify home health providers about the new release date via Listserv.



The Quarterly Q&As are a great in-service tool for your clinical staff. Highlights from the July Quarterly Q&As include:

- The OASIS reporting impact on process measures when ROC is completed late;
- How to deal with patients held in observation into a new certification period;
- Reporting pressure ulcers that are surgically removed without a flap procedure;
- Determining stage and healing status for pressure ulcers covered with a scab; and,
- Clarification on completing M2000 Drug Regimen Review when elements of the review are incomplete.

Oasis

Updated Quality Measure Documents

CMS has posted updated versions of some of its quality measure documents. The documents are helpful, succinct tables that provide the calculation details for each process measure, quality outcome and potentially avoidable event. Updated technical specifications for the OASIS risk models are also available, as are draft specifications for the two proposed readmission measures that should be implemented early next year.

The documents listed above are available at the CMS Home Health Quality Initiatives' website, on the Quality Measures page.

Specific changes include:

- New measures tables that include all measures available on Home Health Compare or CASPER reports;
- Enhanced technical documentation of OASIS risk models, including specifications for all risk factors; and,
- Draft technical specifications for measures of hospital readmission, and emergency department use without hospital readmission, based on Medicare claims data.



Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

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